Division of Licensing and Protection
HC 2 South, 280 State Drive
Waterbury, VT 05671-2060
http://www.dail.vermont.gov
Survey and Certification Voice/TTY (802) 241-0480
Survey and Certification Fax (802) 241-0343
Survey and Certification Reporting Line: (888) 700-5330
To Report Adult Abuse: (800) 564-1612

September 14, 2017

Ms. Nancy Peers, Manager
Brookdale At Fillmore Pond
300 Village Lane
Bennington, VT 05201-9041

Dear Ms. Peers:

Enclosed is a copy of your acceptable plans of correction for the survey conducted on August 22, 2017. Please post this document in a prominent place in your facility.

We may follow-up to verify that substantial compliance has been achieved and maintained. If we find that your facility has failed to achieve or maintain substantial compliance, remedies may be imposed.

Sincerely,

Pamela M. Cota, RN
Licensing Chief

Division of Licensing and Protection

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0310	A. BUILDING: _____ B. WING _____	C 08/22/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BROOKDALE AT FILLMORE POND	300 VILLAGE LANE BENNINGTON, VT 05201

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
R100	Initial Comments: An unannounced onsite investigation for 3 entity reports was conducted by the Division of Licensing and Protection on 8/22/17. There were regulatory findings.	R100	This Plan of Correction is not to be construed as an admission of or agreement with the findings and conclusions in the Statement of Deficiencies, or the proposed administrative penalty (with right to correct on the community. Rather, it is submitted as confirmation of our ongoing efforts to comply with all statutory and regulatory requirements. In this document, we have outlined specific actions in response to each allegation or finding. We have not presented all contrary factual or legal arguments, nor have we idenitified all mitigating factors.	
R145 SS=D	V. RESIDENT CARE AND HOME SERVICES 5.9.c (2) Oversee development of a written plan of care for each resident that is based on abilities and needs as identified in the resident assessment. A plan of care must describe the care and services necessary to assist the resident to maintain independence and well-being; This REQUIREMENT is not met as evidenced by: Based on staff interview and record review, the facility failed to develop a written plan of care for one of four residents, Resident #1, based on the care.and services necessary to assist the resident to maintain well-being surrounding pain. Findings include: Resident #1 has diagnoses that include: chronic persistent pain, arthritis, anxiety and depression and s/he has routine Acetaminophen 1300 milligrams (mg) twice a day and Acetaminophen 650 mg every 6 hours PRN (as needed) for pain. S/he also has an order for Tramadol 50 mg every 6 hours PRN. The resident also has an order to use ice every 8 hours as needed for right sided pain. Review of the service care plans does not provide evidence of how to address the pain, what effect the pain has on his/her abilities to	R145	Attached is the updated Plan of Care for resident #1 addressing her chronic pain management, interventions and goals. All care plans for all residents with diagnosis of chronic pain will be audited to ensure proper pain management is in place. Ongoing resident plan of care is updated every six months or at change of condition and at that time will also be audited for resident-centered plan of care.	9-8-17 10-15-17

Division of Licensing and Protection
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Nancy P. Peers — TITLE: Executive Director — (X6) DATE: 9/13/17

R145-R224 POC's accepted 9/13/17 BBerkellRN/mc

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R145	Continued From page 1 care for him/herself. The Registered Nurse, at 12:30 PM, confirmed that the resident has chronic pain and it will sometimes interfere with his/her daily activities,and there is no service care plan to address the pain and there is no clear plan as what interventions and goals should be used.	R145		
R190 SS=D	V. RESIDENT CARE AND HOME SERVICES 5.12.b.(4) The results of the criminal record and adult abuse registry checks for all staff. This REQUIREMENT is not met as evidenced by: Based on staff interview and record review, the facility failed to have on file the results of adult abuse registry checks for 3 of 5 direct care staff in the sample. Findings include: A review of pre-hire background checks were lacking evidence of adult abuse registry checks for 3 of 5 direct care staff employees. Interview with the business manager at 2:00 PM, s/he stated that no one can start work at the facility without having all applicable background reference checks being completed and without negative findings. S/he also confirmed at this time that s/he had searched the files and there is no evidence that the checks had been completed.	R190	Three employee records were pulled pertaining to this investigation. Two of the three employees did not have background information in their files. The signed consent form and checks were made but printed results were not located. On 8/22/17 results were reprinted and placed in employee files. Going forward all employee files are audited prior to hire to ensure all printed results for background checks along with all pre-hire criteria is in the file at time of orientation. A checklist has been developed to ensure 100% compliance.	8/22/17
R224 SS=G	VI. RESIDENTS' RIGHTS 6.12 Residents shall be free from mental, verbal or physical abuse, neglect, and	R224		

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R224	Continued From page 2 exploitation. Residents shall also be free from restraints as described in Section 5.14. This REQUIREMENT is not met as evidenced by: Based on resident and staff interview and record review, the facility failed to keep one of four residents, Resident #1 free from neglect. Findings include: Resident #1 has diagnoses that include: chronic persistent pain, arthritis, anxiety and depression and s/he has routine Acetaminophen 1300 milligrams (mg) twice a day and Acetaminophen 650 mg every 6 hours PRN (as needed) for pain. S/he also has an order for Tramadol 50 mg every 6 hours PRN. On 4/12/17 at approximately 8:30 AM, Resident #1 first called for assistance to request pain medication secondary to having right abdominal pain, which Resident #1 stated s/he has frequently. Per statements of the Resident Care Assistant (RCA), the Licensed Practical Nurse (LPN) was made aware of the request and responded that s/he "would get to it". A second request for pain medication was made by the resident approximately a half hour later and the LPN was again made aware of the request by the RCA and the LPN responded that "[s/he] would have to wait and [s/he] will get to [him/her]". Resident #1 made a phone call to the receptionist desk to request that someone respond to his/her need for pain medication and the message was relayed to the LPN. At 11:00 AM the resident was found, by an RCA, to be hunched over his/her walker and complaining of the pain in his/her right side. The RCA, who is also medication administration delegated, assisted the resident to the bathroom and then to a seat and attempted to make him/her comfortable. After the resident	R224	The Health & Wellness Director has begun re-educating all nursing, medication techs, and resident care associates on resident rights and pain management. Explanation & discussion of prn medications and what RCAs must do in the event a med tech or LPN/RN does not respond to a resident's request. Further re-education on abuse, including neglect has been given.	10/15/17

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R224	Continued From page 3 was safe, s/he approached the LPN and reported that the resident needed his/her pain medication and the was told by the LPN, "I will get there when I want". The RCA asked the LPN if s/he would like him/her to administer the pain medication and the LPN stated that, "I will give it to her when I have time". Resident #1 was administered Tramadol 50 mg at 11:16 AM, over three hours after the initial request. Resident #1 stated in an interview at 1:30 PM that when she finally got the pain medication it was too late to get the pain under control and it took a long time before s/he began to feel relief. S/he further stated that s/he didn't understand why it would take so long to get the medicine. The Registered Nurse and the Executive Director confirmed at 12:15 PM that the actions of the LPN were neglectful and s/he had been terminated after the facility completed their internal investigation.	R224		